



PATIENT INTAKE FORM

Please print legibly

Date: ___ / ___ / ___ Name: Last Name First Name Middle Initial

Date of Birth: ___ / ___ / ___ Age Height Weight Test Scheduled:

Why did your doctor order this test:

List previous tests performed at Manhattan Diagnostic Radiology and when they were performed:

List previous surgical procedures and date performed:

List any chronic diseases you have:

Do you have a history of kidney disease? Are you HIV or Hepatitis Positive?

Are you Diabetic?

If so, are you currently taking Glucophage (Metformin), Avandamet or Glucovance?

Do you have a history of cancer?

If yes, when and what type:

Have you ever had Chemotherapy Radiation Therapy?

If yes, what type and when was your last session:

Do you have any of the following allergies?

Iodine contrast (dye injection)? Latex?

Medication/Food Allergies? If yes, list :

FOR MRI PATIENTS ONLY: The following items may be hazardous or may interfere with the MRI exam.

Please indicate if you have any of the following:

- Cardiac Pacemaker/Pacemaker Wires
Electronic or Magnetically Activated Implant or Device
Cochlear/Otologic/Other Ear Implant
Any Metallic Fragment/Foreign Body
Internal Electrode/Wire or Metallic Stent/Filter or Coil
Any Type of Prosthesis (cardiac valve, limb, eye, penile, etc)
Other Implantable Device - Specify

PLEASE REMOVE THE FOLLOWING:

- Hearing Aids
Removable dental work
Watches
Cell phone/Pager
Wallets and ALL magnetic cards
Hairpins, clips, barrettes
Keys
Jewelry

Do not enter the MR scanner room if you have any question or concern regarding an implant, device or object.

Consult the MRI technologist BEFORE entering the MR room.

I attest that, to the best of my knowledge, the above information is correct. I read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and the procedure that I am about to undergo. I give permission for the following test(s) to be performed:

Patient Signature

Patient Name

Date

WOMEN OF CHILDBEARING AGE - PLEASE FILL OUT THE SECTION BELOW

In order for us to complete the study that has been requested by your physician, we may be required to take x-rays of a certain area of your body. It has been hypothesized that an unborn child in its 1st trimester would be more sensitive to radiation than an adult. In order to ensure that no fetus (unborn child) be exposed to radiation, please complete the following questions below.

Are you pregnant or experiencing a late menstrual period? Date of last menstrual period

Is there any chance you may be pregnant? Are you breast feeding?

To the best of my knowledge, I am not pregnant, and I have been informed of the effects of radiation on an unborn child and consent to having the x-rays taken.

Patient Signature

Patient Name

Date